
Advancing Policies for Quality Malnutrition Care in Older Adults:

A Toolkit for Constituents and Driving Change



defeat malnutrition today

About Defeat Malnutrition Today

The Defeat Malnutrition Today coalition is a diverse alliance of over 100 national, state, and local stakeholders and organizations, including community, healthy aging, nutrition, advocacy, healthcare professional, faith-based, and private sector groups. The coalition shares the goal of achieving the recognition of malnutrition as a key indicator and vital sign of older adult health risk; it works to create policy change toward a greater emphasis on screening, detecting, diagnosing, treating, and preventing malnutrition.

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About Women In Government (WIG)

Women In Government is a national, non-profit, non-partisan organization of women state legislators. Women In Government has provided leadership opportunities, networking, expert forums, and educational resources for more than 30 years on policy issues such as education, energy, the environment, healthcare, technology, transportation, and more.

Women In Government

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Dear State Advocate:

The purpose of this toolkit is to provide information on the issues of malnutrition and how to communicate to your state policymakers about the impact of malnutrition on the older adult population. Included are resources addressing how malnutrition is a growing but preventable problem in America today, what policy changes can help decrease malnutrition, how multiple states are taking action, and how you can help influence your state policymakers to do the same.

A collaborative effort among key stakeholders and advocates in the public and private sectors is required to reduce and prevent malnutrition among older adults across the country. The Defeat Malnutrition Today coalition and its more than 100 members along with Women In Government are proud to offer you this toolkit. It is hoped that the policy actions presented will help provide the framework necessary to achieve success in preventing and treating malnutrition among older adults. We encourage you to use this toolkit to raise awareness about malnutrition and develop policies and implement real-world solutions to combat this public health crisis affecting so many older adults and their families in America today.

Good nutrition is important for everyone. It is particularly critical for our nation's older adults; older adult malnutrition is a growing crisis in America today. The cost of disease-associated malnutrition in older adults is high—estimated to be \$51.3 billion per year.¹ Up to one out of two older adults is either at risk of becoming or is malnourished, yet insufficient attention is given to preventing and treating the condition. This is where you can help.

The COVID-19 pandemic has greatly impacted our social determinants of health. It has increased the challenges for already vulnerable populations and revealed the increased need for strengthened systems and policies to support them. Because of the pandemic, many older adults are isolating themselves, which may limit their access to food, particularly healthy food. Many seniors also face food insecurity. Prior to the pandemic, Feeding America reported that 7.3% of older adults were food insecure and 2.7% were very low food insecure. This translated into 5.3 million and 2.0 million seniors facing food insecurity or very low food insecurity.²

COVID-19 has significantly changed the economic landscape, and unemployment rates are rising. Feeding America predicts that if the unemployment rate increases to 7.6%, food insecurity may increase by 5.2%.³ Such growth in food insecurity nationwide will likely increase rates of food insecurity among seniors too, as many often continue to work beyond age 65, and thus older adult malnutrition rates may grow as well.

Malnutrition, particularly lack of adequate protein, is a patient safety risk and can have deleterious effects on health, especially when other medical conditions are present. Specifically, it can increase mortality rates, readmission rates, and complication rates such as increased length of stay and cost of care. But, it is also preventable. With effective screening, assessment, diagnosis, and intervention, malnutrition can be identified and addressed to benefit older adults and health outcomes.

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Table of Contents /

Top-line Summary	5
Advocacy and Making a Difference	7
Communicating with Your State Legislator	9
Everyone’s Voice Matters	11
Sample Script for Phone or Email Outreach to State Legislators	12
Exploring the Malnutrition Issue	13
The Cost of Malnutrition	17
Social Determinants of Health, Food Security, and the COVID-19 Pandemic	18
A Quality Focus for Malnutrition Care	19
A Blueprint for Success in Achieving Quality Malnutrition Care	21
Taking Policy Action on Older Adult Malnutrition	22
State Best Practices	23
Appendices	26
Appendix A: Federal Nutrition Assistance Programs Serving Older Adults and Opportunities for State Legislators	26
Appendix B: Sample Social Media	28
Appendix C: Sample Graphics	30
Appendix D: Resources on Health and Nutrition Advocacy and Malnutrition	31
Appendix E: Sample Resolution Recognizing Malnutrition Awareness Week	32
Appendix F: Qualified Clinical Data Registries (QCDRs)	33
Appendix G: State Costs of Disease-Associated Malnutrition	34
Appendix H: Malnutrition Policy Through the Decade	36
Appendix I: Sample Malnutrition and Food Insecurity Screening Tool	37
Appendix J: Glossary of Terms	39
References	41

Top-line Summary /

Malnutrition is an imbalance in energy, protein, or nutrients that adversely impacts an individual's own body form, function, and clinical outcomes.⁴

Older adult malnutrition is a growing crisis

- Up to one out of two older adults is either at risk of becoming or is malnourished^{5,6}
- Disease-associated malnutrition in older adults is estimated to cost \$51.3 billion annually¹

Malnutrition is a patient safety risk and can impact healthy aging and health outcomes

- Yet malnutrition is often not identified or treated
- According to the Academy of Nutrition and Dietetics⁷:
 - Between 20% and 50% of adults are at risk of becoming or are malnourished upon admission to the hospital, yet only 8% are diagnosed
 - The gap occurs for a number of reasons, including how malnutrition care information is tracked in electronic medical record systems
 - Malnourished hospitalized patients are up to five times more likely to have an in-hospital death and have a 54% higher likelihood of hospital 30-day readmissions, compared to non-malnourished patients, according to two recent AHRQ Hospital Cost Utilization Project analyses
 - The cost per readmission for patients with malnutrition (versus patients readmitted without malnutrition) was \$17,500—26%-34% higher, depending on the specific type of malnutrition

Malnutrition care is recognized as an important gap area⁸

- However, there are no state public health goals on malnutrition, and malnutrition quality measures are not included in quality incentive programs
- The *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* identifies specific areas of stakeholder collaboration that can help raise awareness about and address the issue of malnutrition⁸
- COVID-19 has revealed the importance of telehealth as an opportunity to stay connected to patients. Telehealth connects registered dietitian nutritionists with patients who may be at risk for malnutrition or are already malnourished



State legislators can take action

Malnutrition policy actions are needed now!

- Proactive legislative and public health policy actions can help ensure quality malnutrition care is included in preventive and social services, patient safety, care transitions, and population health strategies for older adults
- Policy actions can include establishment of a Malnutrition Prevention Commission for Older Adults, recognition of Malnutrition Awareness Week^{TM9} through a resolution, and the inclusion of strategies related to malnutrition care in state healthcare quality improvement initiatives
- Other policy actions particularly important during the COVID-19 pandemic but also critical for long-term solutions to older adult malnutrition include supporting legislation to increase funding for congregate and home-delivered meals; providing information and encouragement to constituents to sign up for food assistance programs; advocating for state waivers to simplify enrollment in the federal Supplemental Nutrition Assistance Program (SNAP). **Refer to Appendix A to see what federal nutrition plans are affected by changes at the state level**

Advocacy and Making a Difference /

What Is Advocacy and Why Is It Important?

Advocacy is the act or process of supporting a cause or proposal at a local, community, state, or federal level. Through advocacy, issues are identified and support is garnered to help educate or change public views or influence public policy that affects the issue. Advocacy ensures that the voices of stakeholders (you, your family, and your community) are heard. It can be as simple as calling, texting, emailing, or reaching out via social media to your elected officials to inform them of an issue or creating an outreach event with local or state representation. When many people come together and advocate for an issue, their voices and actions can create change.⁴

Advocacy is critical to the democratic process and empowering change at local, state, and national levels. Legislators need to hear from their constituents (you!) about issues that affect communities and vulnerable populations.



How to Be a Strong Advocate

Taking the following steps can help you advocate more effectively⁴:

1. Know the goals of your advocacy

Advocating for malnutrition in older adults is important to increase awareness and inform state legislators of the issue as well as encourage them to implement policies that increase screening, intervention, and resources for malnourished older adults. More specific goals from the National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update can be found on page 20.

2. Create a plan on how to accomplish your goals

This toolkit provides tips on communicating with your state policymaker and offers supporting information to share with them about why malnutrition in older adults is an important issue. Information in the following sections will be helpful as you develop your plan.

3. Consider the point of view of your audience

Are you talking to your community about the issue of malnutrition in older adults to bring awareness or are you sending an email to your state legislator about how malnutrition impacts your state and how much it costs? The top-line summary on page 6 provides quick facts that may be helpful as you tailor your request to your audience.

4. Understand whether or not your audience has the authority to make change

Make sure you are advocating to the individuals who can create change.

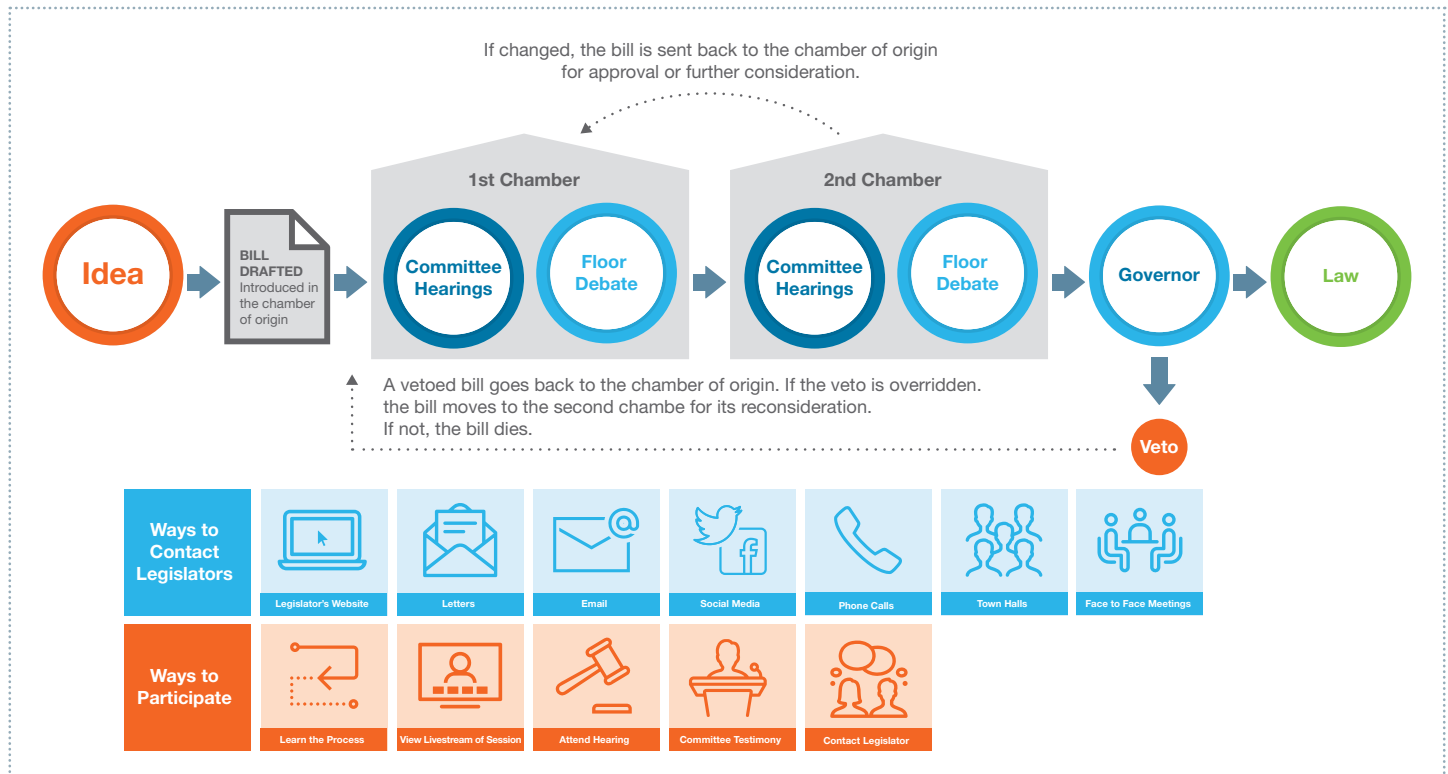
5. Make your case

Let state policymakers know the facts about malnutrition and how it affects your community and state. Give your state policymakers specific suggestions and action steps to help fight malnutrition. Detailed information on the malnutrition issue, starting on page 12, can help you make the case for addressing older adult malnutrition.

State Legislative Process

State legislative processes vary slightly by state but in general are closely aligned with the federal legislative process. State legislative sessions commonly begin in January and may continue for 3 to 4 months or longer.⁴ There are 32 states that are usually in session for 3 or 4 months; they begin in January and end in May. Six state legislatures (California, Connecticut, Delaware, Louisiana, Maine, and Oregon) start their sessions in January and continue into the summer. Eight states (Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Wisconsin) and the District of Columbia have sessions year-round. Four state legislatures (Montana, Nevada, North Dakota, and Texas) are in session every other year.

State Legislative Process



How a bill becomes a law

- An idea for a bill is shared with a state legislator and/or their staff
- A bill is drafted and then introduced by the chamber of origin
- The bill goes to the first chamber and is assigned to a committee. The committee decides if the bill should be added to the calendar for a hearing to get feedback on the proposed legislation
- The committee decides whether to kill the legislation, make changes to it, or vote to send it to the complete chamber for a floor vote
- Legislators deliberate the bill, may amend it, and take a floor vote
- » If the bill is approved, it goes to the second chamber to follow the same process
- » If the bill is amended by the second chamber, the first chamber has to approve the changes made and the bill may go to a conference committee that has members from both chambers to come to a decision
- After the bill is passed, the governor may sign it or veto it. There are some states where a bill can become law without the governor's signature
- If the governor vetoes the bill, the legislature can sustain or override the governor's veto. Vetoed bills go back to the chamber of origin, and then the second chamber has to reconsider the bill. If the bill is not reconsidered, it dies.

Communicating with Your State Legislator /

To be a strong advocate, you need to have consistent, clear communication with your state policymaker and their staff and tell them why your issue is important (see sample script on page 11). In this section, we provide summaries and information to help you formulate your interactions with legislators and other policymakers.

There are over 7,000 state policymakers nationwide. Their job is to identify and address issues, including passing new legislation or changing current laws to meet the needs of their constituents (you). State legislators can engage the executive branch by requesting information and/or policies from the governor, cabinet agencies, commissions, etc.

Legislators often serve on committees or subcommittees targeting specific policy areas. However, legislators are usually generalists versus experts on particular issues, and they rely on state legislative staffers (there are over 30,000 nationwide) to help keep them informed, run the office, communicate with constituents and other state government offices, and provide research for the many policy issues state legislatures consider.

Find out who your state legislators are by visiting <https://www.congress.gov/state-legislature-websites>.

Ways to communicate with state legislators and raise awareness about malnutrition

Connect directly with state or local representative

- Call the office and speak to the scheduler 2-3 weeks in advance of the date you would like to have your meeting or go to the legislator's website to fill out an online form. The top-line summary on page 5 may be a useful handout to share and leave behind with your legislator and their staff and will direct state legislators to the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*.

Use social media to engage legislators and the community in the issue of malnutrition

- Newer legislators, legislators with fewer staff, or legislators that recognize the effectiveness of these platforms utilize it.

- Examples of information to share on malnutrition:
 - Up to one out of two older adults is either at risk of becoming or is malnourished.
 - Disease-associated malnutrition in older adults is estimated to cost \$51.3 billion annually in the US.
 - Between 20% and 50% of adults are at risk of becoming or are malnourished upon admission to the hospital, yet only 8% are diagnosed. See Appendix B for additional disease-specific examples.

Offer your experience and expertise in messaging or testimonials

- Provide the office with a pre-written message mentioning a personal experience or work with a communications staffer for messaging on the legislator's website or newsletter.

Organize an in-person or virtual malnutrition advocacy day; see Appendix C for graphics that may be useful.

- There are many public or lobbying days throughout sessions. Check out the calendar for more ways to get involved: <https://www.ncsl.org/meetings-training/ncsl-meetings-calendar.aspx>

Create an outreach event with state or local representation at a legislator's district office, a community site, or the state Capital.

- Work with a meal site, nursing home, or rehab center and the legislator's scheduler and/or constituent liaison to coordinate a date/time/place for 30 minutes to an hour of their time either in person or virtually.

Attend government public meetings, constituent town halls, and other events to inform policymakers and communities about older adult malnutrition and how to help.

Find meetings here:

- <https://www.mass.gov/event/commission-on-malnutrition-prevention-among-older-adults-2019-02-28t103000-0500-2019-02> and ways to be prepared both listen in or participate.

Resources on health and nutrition advocacy and malnutrition that may be helpful as you reach out to your legislator are available in Appendix D.

Communication tips

Make an ask upfront—for example, ask a legislator to support Malnutrition Awareness Week™ or help create a Malnutrition Coalition in your state. See Appendix E for a sample resolution recognizing Malnutrition Awareness Week™.

- Make sure your communication is clear and concise.
- Stick to the issue: in this case, malnutrition. If you mention multiple issues, you are less likely to get a specific response.
- If you are using a sample letter, make sure to add personal experience about how you or someone you know has been affected by the issue of malnutrition.
- Be aware of your state’s legislative calendar: Legislation does not occur yearly in some states. It’s helpful to know when session dates, committee meetings, and filing deadlines are. Check out <https://www.ncsl.org/meetings-training/ncsl-meetings-calendar.aspx> to stay informed
- Come up to speed by researching committee rosters and browsing current, pending, or missing policies on malnutrition before contacting or meeting with your legislator. Here’s how,
 - Visit: <https://www.defeatmalnutrition.today/>
 - Check out: <http://www.nutritioncare.org/Malnutrition/>
- Build relationships with policymakers. Here’s how:
 - Connect with legislators on social media (handles can be found on legislators’ state legislative pages, non-legislative personal pages, or Ballotpedia)
 - Sign up to receive legislators’ newsletters (preferably at least one from the lower chamber and one from the upper chamber)
 - Attend constituent meetings in person and virtually to make your voice heard and to become familiar with the process and acquainted with the legislator

It’s important to build relationships with staff and key volunteers in both Capitol and district offices: schedulers, constituent liaisons, legislative directors, and others.

Suggestions include:

- Staying in communication with emails, phone calls, letters, and social media
- Attending town halls and district meetings virtually or in person
- Showcasing how the issue of malnutrition is aligned with their agenda
- Advocating between sessions
- Making your interactions personal by remembering their names, sharing your name, city and state, and telling a personal story of how malnutrition is affecting you or your community

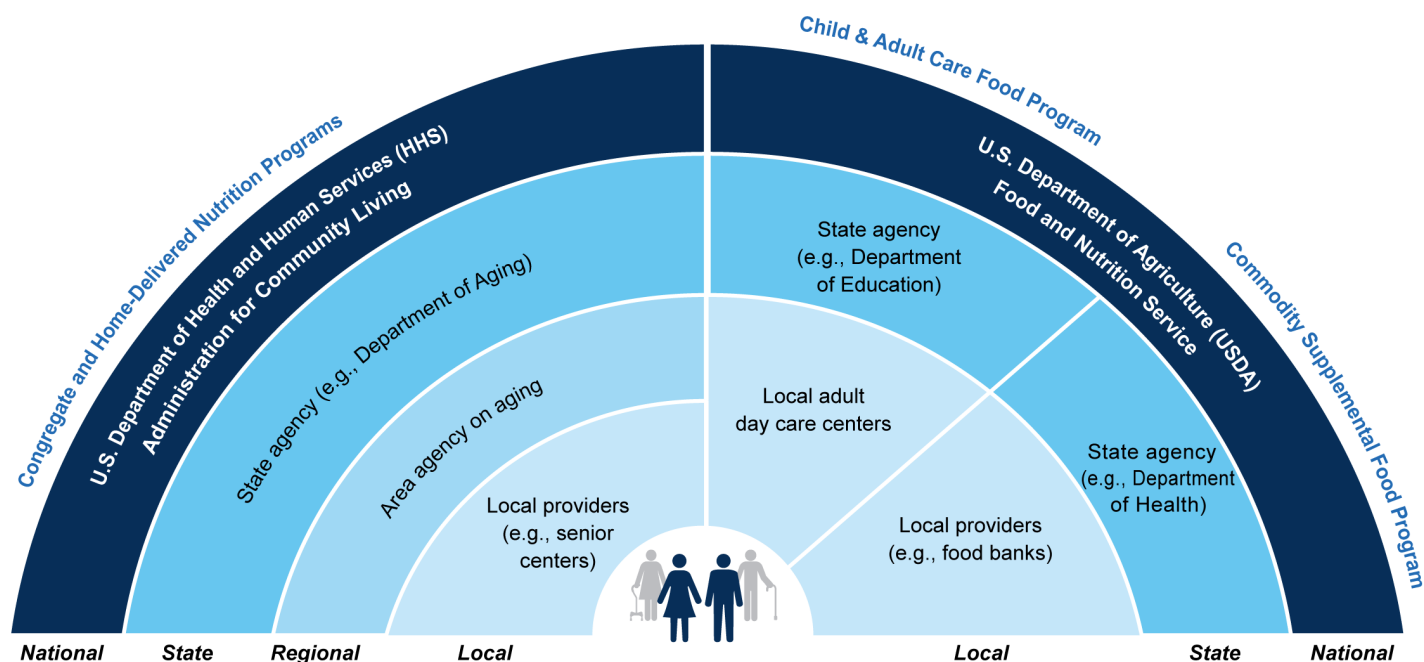
Don’t forget that there is power in being a registered voter. Make sure you and members of your community are registered to vote and vote in your local and state elections.



Everyone's Voice Matters: /

It takes a village to address complex issues such as malnutrition and food security. It also takes the work of local, regional, state, and national advocates and policymakers to create change over time.

Stakeholders Involved in Administering Selected Nutrition Assistance Programs That Directly Provide Meals and Food to Older Adults



Source: GAO analysis of HHS and USDA program information and interviews with HHS and USDA officials. | GAO-20-18

Resource Links for Meals and Food Assistance Programs for Older Adults

Meals on Wheels Program Locator: <http://bit.ly/find-HDM>

Food Bank Locator: <http://bit.ly/find-foodbank>

SNAP Information: <http://bit.ly/SNAP-apps>

The Emergency Food Assistance Program (TEFAP) Link to Local State Agency Contact Information: <http://bit.ly/TEFAP-contacts>

Sample Script for Phone or Email Outreach to State Legislators /

I am a constituent of yours from [City], and I wanted to talk to you about malnutrition. Malnutrition is a serious and costly public health crisis—here in [State] and across our nation! Older adult malnutrition in particular is associated with unfavorable health outcomes including higher infection rates, poor wound healing, longer lengths of stay, and higher frequency of hospital readmission. **[Reminder: Use a personal or local example of effects of malnutrition]**

Because of the COVID-19 pandemic, many older adults are isolating themselves, which may limit their access to good nutrition and healthy food. Not unexpectedly, the poor health outcomes of malnutrition are associated with higher costs to our healthcare system and state.

Yet, despite its severity and prevalence, and the fact that it is both TREATABLE AND PREVENTABLE, older adult malnutrition is too often misunderstood by the American public and overlooked by our healthcare system.

For these reasons, I want to urge you to [introduce/co-sponsor] [legislation or, if there is a bill already introduced, specific bill number] to begin to address this severe public health crisis among our older adults by [description of the specific state legislation.]

[Discuss details about the legislation. For example, for a bill related to creating a Malnutrition Prevention Study Commission, explain: This Commission will document the problem by studying the impact of older adult malnutrition across care settings throughout the state, find evidence-based solutions by investigating the most effective strategies, and recommend systems of care to monitor the influence of malnutrition on older adult's healthcare costs, outcomes, quality indicators, and quality of life measures.]

This legislation is a step in the right direction to stopping malnutrition before it impacts any more of our older adults.

Other actions state legislators could take include helping establish a malnutrition prevention commission, recognizing malnutrition week through a resolution, and supporting strategies related to malnutrition care in state healthcare quality improvement initiatives.

Please consider [introducing/supporting] [legislation or specific bill number] to help end malnutrition in our state. [If the legislator has already taken action on issues of malnutrition, be sure to thank them for their efforts.]

Key Takeaways

Advocacy amplifies the voice of stakeholders. It is an opportunity to help make change in your community, state, and country.

- Make an ask! Tell policymakers what you want them to do to improve malnutrition.
- Remember clear and concise communication is best.
- Connect with a call, text, email, and/or social media.
- Attend government public meetings to stay informed.
- Always add a personal touch on how the issue of malnutrition is affecting you or your community.
- Register to vote and make sure members of your community are registered to vote. There is power in your vote at the local, state, and federal level.
- Inform your community of how to access local programs like Meals on Wheels, Supplemental Nutrition Assistance Program (SNAP) benefits, and Congregate Meals programs and how they help communities fight food insecurity.

Exploring the Malnutrition Issue /

Why Is Quality Malnutrition Care Such an Important Issue?

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)⁸

High-quality nutrition and malnutrition care for older adults should be at the top of the state agendas as we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost and tackle social determinants of health.

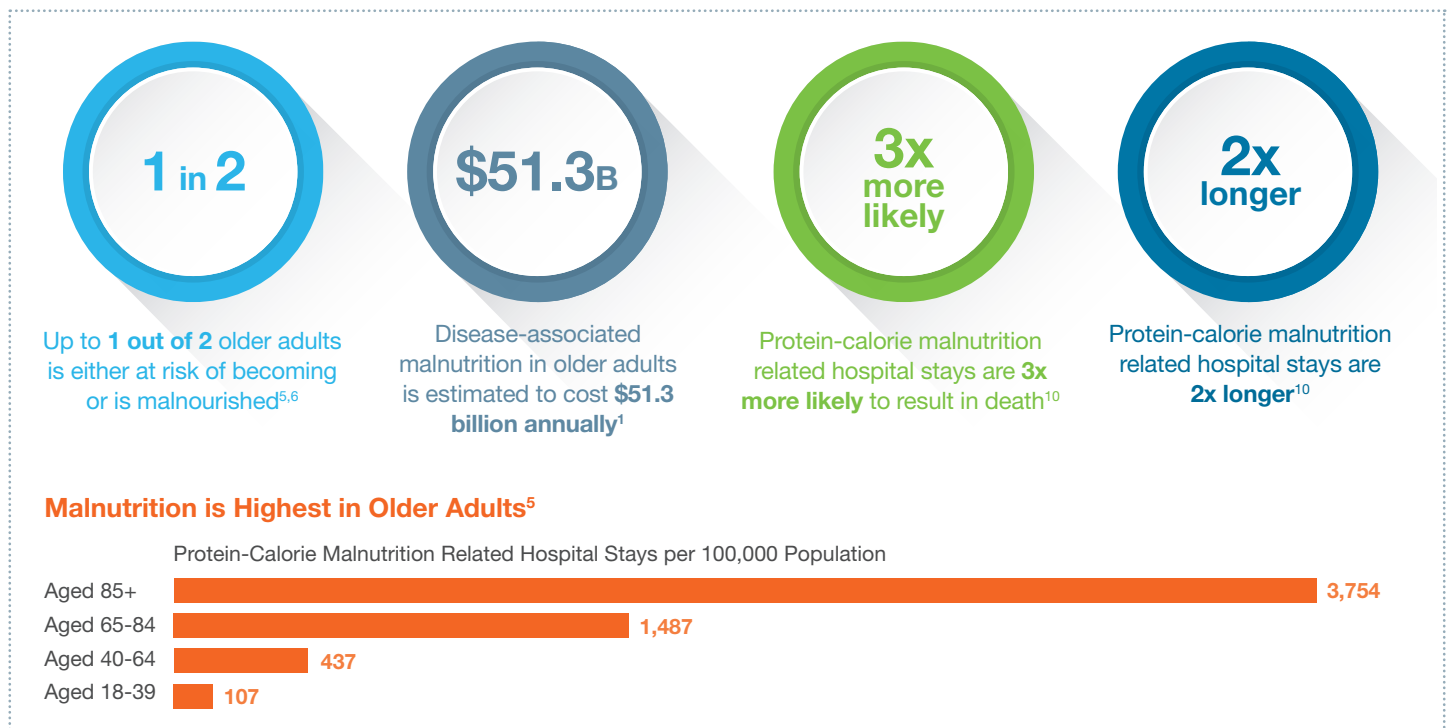
An increasing body of statistics and health economics data shows the costs in human and economic terms of malnutrition among this age group (Figure 1). With the number of adults aged 65 years and older expected to reach 77 million by 2034, and Medicare spending projected to rise at a higher rate than overall health spending, there is an urgency to secure the future of “healthy aging,” starting with nutrition.

Nutrition has been referred to as a vital sign of older adult health. Good nutrition has been shown to help support a healthy and active lifestyle, improve health outcomes, and reduce healthcare costs. In stark contrast, malnutrition, particularly the lack of adequate protein, calories, and other

nutrients needed for tissue maintenance or repair, has been shown to be associated with poor health outcomes, frailty and disability, and increased healthcare costs. Importantly, malnutrition is a significant problem for both underweight and overweight or obese individuals due to loss of lean body mass. Moreover, generally when people reference malnutrition, it is protein-energy malnutrition.

The causes of malnutrition are multiple and complex, and the solutions require collaboration among many government bodies, organizations, and communities. To coalesce the key stakeholders and focus additional attention on older adult malnutrition, the Defeat Malnutrition Today coalition (www.defeatmalnutrition.today) and Women In Government (www.womeningovernment.org) developed and created this Toolkit for State Constituents.

Figure 1: Malnutrition is a Critical Public and Patient Safety Issue (*national data*)



Poverty and food insecurity significantly increase the risk of malnutrition. At the same time, there are additional risk factors to consider (Figure 2). Changes commonly associated with aging, such as loss of appetite, limited ability to chew or swallow, and use of multiple medications, can impact diet and nutrition.

Pandemic health measures, such as stay-at-home orders, can cause social isolation and limit access to food and contribute to malnutrition.

Older adults are also at risk of malnutrition due to chronic illness, disease, injury, and hospitalization. Acute conditions, like those that require surgery, as well as chronic diseases such as cancer, diabetes, and gastrointestinal, lung, and heart diseases and their treatments, can result in changes in nutrient intake that can lead to malnutrition.

Further, with disease-associated malnutrition, inflammatory responses are increased, which can result in decreased appetite, gastrointestinal problems, diminished immune response, delayed wound healing, and increased infection rates. Such changes can increase risks for functional disability, frailty, and falling. Changes in functional ability can also lead to social isolation, which may cause depression and, in turn, affect cognitive functioning. Changes in cognitive functioning for some older adults may also be risk factors for malnutrition.

Many of the risk factors for older adult malnutrition are also risk factors for both contracting and developing more severe complications from acute respiratory viruses such as COVID-19.

Evidence shows the severity of COVID-19 infection is compounded by its effect on nutrition, especially for the critically ill. More specifically:

- A higher prevalence of malnutrition (53% malnourished, 28% at risk of malnutrition) has been documented among older patients admitted to the hospital with COVID-19¹¹
- Most patients admitted to intensive care with COVID-19 were acutely malnourished,¹² and 45% of patients admitted to a rehabilitation unit following COVID-19 infection were at high risk for malnutrition¹³
- Malnutrition's health impacts, particularly on respiratory and cardiac function, can likely affect the course of recovery of patients with COVID-19¹⁴
- Nutrition status has been identified as an important factor influencing the outcome of COVID-19 patients¹⁵
- COVID-19 is often accompanied by prolonged immobilization, which can increase risk for muscle wasting and protein loss¹⁶

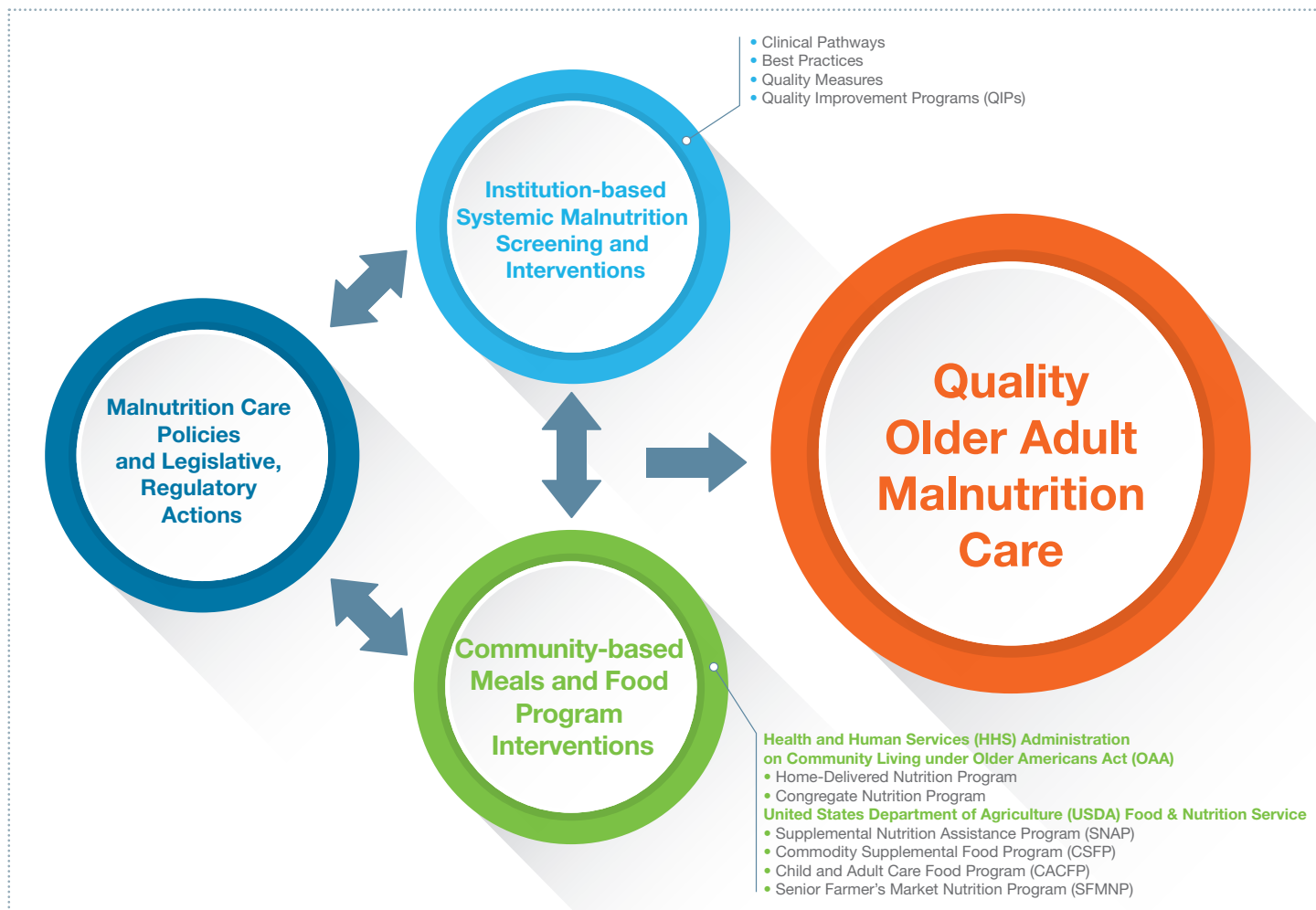
Figure 2: Contributing Factors that Lead to Malnutrition Among Older Adults⁸



Once malnutrition or risk for malnutrition is identified in older adults, there are important institution and community-based interventions that should be implemented. Both levels of intervention can be impacted by malnutrition care

policies and legislative and regulatory actions (Figure 3). Additional information on community-based meals and food program interventions is provided in Appendix A.

Figure 3: Factors Influencing Quality Malnutrition Care for Older Adults



But while malnutrition is pervasive, costly, and causes patients to feel worse and heal slower, it has not yet been addressed by a systematic, consistent approach throughout the healthcare system.

Broadly, there is a general lack of awareness that malnutrition is linked to acute illness, chronic disease, and poor health outcomes. In addition, physicians and other clinicians receive limited nutrition training in medical schools and allied health programs. Many individuals among the public, including healthcare providers, are unaware of malnutrition's prevalence in older adults and are therefore limited in their ability to help identify and address the condition.

As our nation moves to expand telehealth services, there is an opportunity to integrate malnutrition screening in telehealth programs and other provider access initiatives.

While widespread expansion of telemedicine is positive, it could also further increase rather than reduce healthcare disparities, particularly for those older adults with sensory impairments, limited digital literacy and access to technology (including those in rural communities), lower incomes, and poor health literacy. There is also the potential for discrimination and mistrust to be magnified during virtual encounters, when patients may feel more

limited in their ability to communicate and providers may be less mindful of guarding against implicit bias. Thus, as states explore providing broader access to telehealth, it will be important to consider adaptations based on urban/rural communities or other divides that limit access to the internet and reliable cell phone services, as well as develop solutions for increasing digital literacy.

In addition, care coordination of malnourished and at-risk older adults could be less fragmented if there were greater visibility among the clinical care team of relevant malnutrition data and documentation and standardization of key malnutrition data elements in electronic health records.

Malnutrition care represents an important gap area that has been acknowledged by the Centers for Medicare & Medicaid Services (CMS). Yet, malnutrition has not been included in our governmental health objectives, nor is it reported in key health indicators for older adults or integrated into public or private quality incentive programs.

State legislators can take action by including malnutrition in state health objectives and by urging the federal government to follow the lead of states.

However, there has been initial movement, as CMS approved including malnutrition quality measures in two Qualified Clinical Data Registries (QCDRs) for 2020 in the Merit-based Incentive Payment System (MIPS). Approval for the malnutrition quality measures in the MIPS may lead to states getting more funds for malnutrition care. The malnutrition quality measures are included in the Premier Clinician Performance Registry and the US Wound Registry to help promote team collaboration with measures for outpatient physicians and dietitians reporting (Appendix F). Thus, clinicians who are providing quality malnutrition care will be able to report with these measures to help receive credit for quality care. Quality of care credit is a core determining factor for performance-based adjustments to Medicare reimbursement, which can impact overall provider financial viability. The 2020 reauthorization of the Older Americans Act also called for malnutrition screening for participants in senior nutrition programs, such as Meals on Wheels and congregate meals.

Key Takeaway

The time to act is now! In a healthcare environment focused on healthy aging, preventive care, patient-centeredness, and cost efficiency, systematic malnutrition screening and appropriate multidisciplinary intervention must become a mainstay of US healthcare. The COVID-19 health pandemic has underscored that poor nutrition may be a relevant factor influencing the health outcomes of older adults. The value of quality malnutrition care must be realized, and our country's healthcare delivery, social services, and financial incentives must be aligned to address the epidemic of malnutrition in acute care, post-acute care, and community settings.

The Cost of Malnutrition /

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)⁸

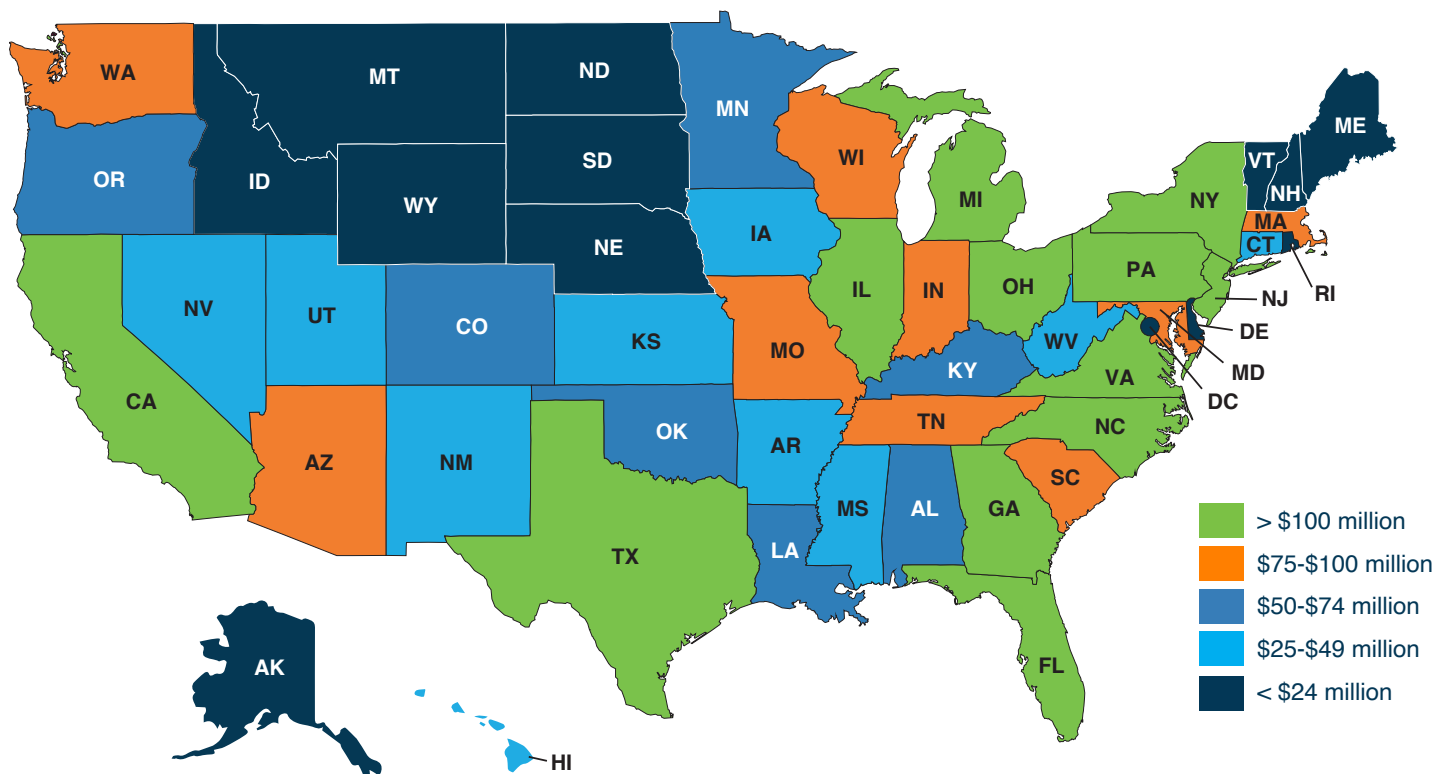
Malnourished older adults make more visits to physicians, hospitals, and emergency rooms¹⁵ and are more likely to have increased rates of medical complications, including falls, delayed wound healing, increased infections, and increased hospital readmissions.¹⁶⁻²⁰

Disease-associated malnutrition occurs when nutrient intake decreases and inflammatory responses increase.²¹ A study examined and quantified state level economic burden (as measured in direct medical costs) of disease-associated

malnutrition to “help policy makers more completely understand the magnitude of the problem and provide support for policy changes needed to better identify, prevent, and treat malnutrition.”²² The results of this study identified 12 states that have an annual economic burden of over \$100 million for disease-associated malnutrition in older adults (Figure 4).

Further details on the annual economic burden of older adult malnutrition by state are provided in Appendix G.

Figure 4: State Economic Burden of Disease-Associated Malnutrition in Older Adults²²



Social Determinants of Health, Food Security, and the COVID-19 Pandemic /

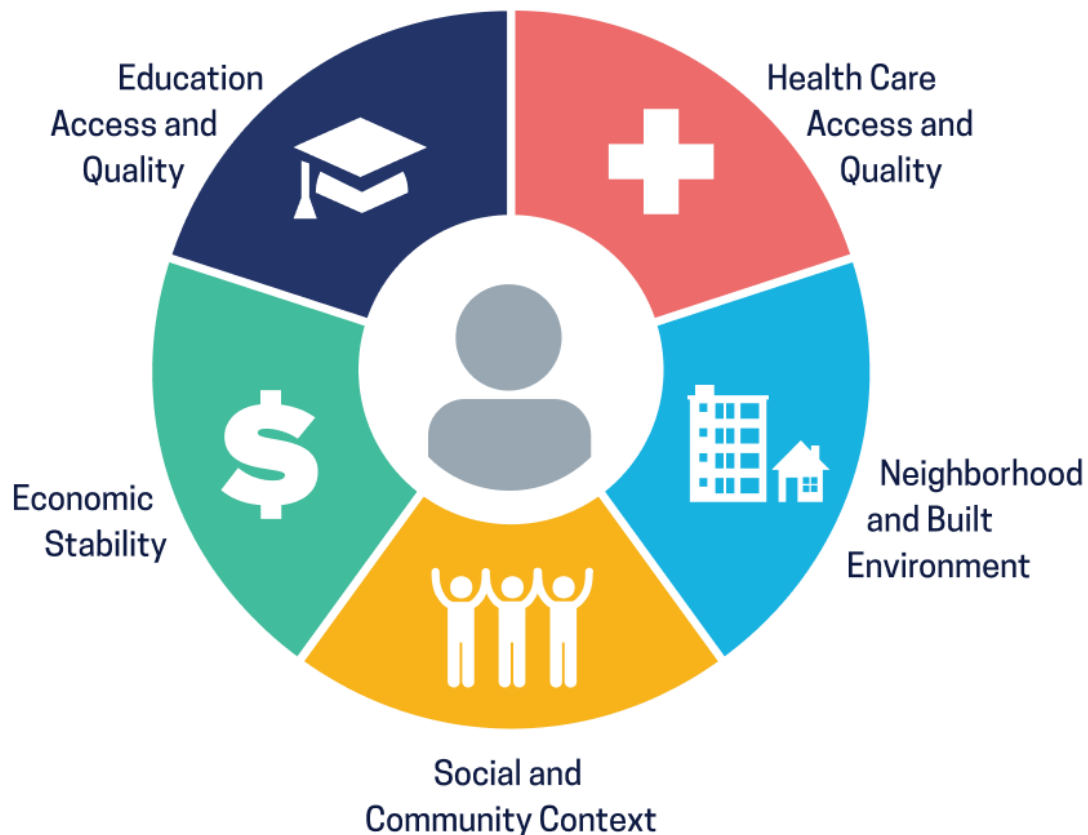
The COVID-19 pandemic has greatly impacted social determinants of health,²⁷ which are the physical, social, economic, and other conditions where people live, learn, work, and play that influence individuals' health and health outcomes. For older adults, COVID-19 has led to decreased contact with others and staying home more. This can decrease their access to nourishing food and socialization, which impact both their mental health and appetite.

Another outcome of the COVID-19 pandemic is rising rates of food insecurity. Before the pandemic, 5.3 million older adults were food insecure and 2 million were very low food insecure. A food insecure²⁶ household is defined as an economic and social condition of limited or uncertain access to adequate food. COVID-19 has drastically increased the unemployment rate, and many of those unemployed are older adults due to

the large number of seniors who continue to work beyond age 65 years. With growing unemployment rates, there are growing food insecurity rates that affect older adults.

Food insecurity and malnutrition have compounded the effects of the COVID-19 pandemic for older adults. Older adults who are food insecure have an increased risk for malnutrition, and those who are malnourished can have increased infection rates. As documented earlier, older adults with COVID-19 may be more likely to be malnourished, and malnutrition may impact their course of recovery.

COVID-19 has revealed the need to strengthen and increase local and state support for community nutrition programs and to fully leverage the availability of federal funds supporting Older Americans Act programs.



A Quality Focus for Malnutrition Care /

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)⁸

With the ever-increasing proportion of older adults in the US population, state legislators may be supportive of promoting public health policies—like high-quality malnutrition care—that help keep older adults healthy and active. This begins by establishing malnutrition public health goals and quality measures that will evaluate the effectiveness of healthcare systems in providing malnutrition care. Currently, there are hundreds of quality measures and many that are required for quality incentive programs. However, until more recently, there have been no quality measures for malnutrition care, and there are still none for malnutrition care required in quality incentive programs.

Policies and actions to promote high-quality malnutrition care provide the impetus needed to implement basic practices that have yet to be embraced by the broader US healthcare system. For example, in both acute care and post-acute care settings, simple shifts in institutional training to emphasize malnutrition screening and assessment are important first steps to potentially reduce the number of untreated cases of malnutrition. This can be strengthened with best practices and quality standards and measures for malnutrition adopted across the continuum of care, including through telehealth services.

Best practices, such as the Global Leadership Initiative on Malnutrition (GLIM) criteria for the diagnosis of malnutrition, the 2019 standards developed by the American College of Surgeons on geriatric surgery, or those specified for Enhanced Recovery After Surgery (ERAS) techniques, include recommendations on malnutrition care. Further, advances are being made for older adult care in the acute care setting through the Malnutrition Quality Improvement Initiative (MQii)—a collaboration of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders.²⁴

The MQii provides an innovative approach that recognizes the need to drive quality through the combined use of electronic clinical quality measures and an interdisciplinary toolkit to help hospitals achieve their performance goals for malnutrition care of older adults.²⁵ In addition, there are over 260 hospitals (both public and private) across the country that are enrolled in an MQii Learning Collaborative and are using the toolkit and

electronic clinical quality measures in order to raise awareness and build an infrastructure for ongoing quality measurement and improvement, including through data sharing.

There is an opportunity to include similar malnutrition-related quality measures in state policies that are targeted to help decrease state Medicaid spending.

There is also a need to evaluate the effect of specific programs, such as home-delivered meal programs, on patient outcomes, particularly as there are now opportunities for Medicare Advantage plans to offer a home-delivered meal benefit to enrollees with chronic conditions. Currently, state nutrition guidelines do not address the varying needs of older adults, yet such guidelines serve as a basis for nutrition requirements in congregate and home-delivered meal programs. A 2019 Government Accountability Office (GAO) report on nutrition assistance programs found that providers of congregate and home-delivered meal services face challenges meeting older adults' needs for certain meal accommodations.

A Quality Focus for Malnutrition Care (cont.) /

Key Takeaways

- One in two older adults is at risk of becoming malnourished or is malnourished.
- Disease-associated malnutrition is estimated to cost the US \$51.3 billion annually.
- Malnourished older adults make more visits to emergency departments, hospitals, and physicians.
- The older adult population is growing rapidly, which will impact the rates of malnutrition and cost of disease-associated malnutrition annually.
- Factors that contribute to malnutrition among older adults are social and mental health risk factors, disease-associated risk factors, function-associated risk factors, and hunger and food insecurity risk factors.
- Malnourished older adults have higher risk for COVID-19 and have increased severity of COVID-19 symptoms.
- COVID-19 has increased the effects of food insecurity and malnutrition. It has revealed the need for stronger local and state support for community nutrition programs.
- Malnutrition should be included in government health objectives and reported as a key health indicator for older adults.
- Increased screening for malnutrition can possibly increase the number of treated cases of malnutrition.
- Quality measures for malnutrition included in state healthcare policies may lead to decreased Medicare spending.
- The Malnutrition Quality Improvement Initiative (MQii) provides resources to help healthcare institutions achieve their performance goals for malnutrition care for older adults.



A Blueprint for Success in Achieving Quality Malnutrition Care /

To coalesce key stakeholders and focus attention on older adult malnutrition, the Defeat Malnutrition Today coalition and Avalere Health led the development, launch, and update of the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*.⁸

The *Blueprint* outlines specific goals and strategies for state governments to take action to promote and achieve high-quality malnutrition care across the continuum of acute, post-acute, and community settings. A selection of the recommended strategies are shown in Table 1.

Table 1: Recommendations for Older Adults, Families, Caregivers, Patient or Consumer Advocacy Groups, and Aging Organizations to Improve Quality of Malnutrition Care for Older Adults

Goal 4: Advance Public Health Efforts to Improve Malnutrition Quality of Care	
Strategies	Recommendations
Train healthcare providers, social services, and administration on quality malnutrition care	<ul style="list-style-type: none"> Require state-based home care standards for training all home-based care givers regarding nutrition, food safety, and identification of the signs and symptoms of malnutrition
Educate older adults and caregivers on malnutrition impact, prevention, treatment, and available resources	<ul style="list-style-type: none"> Participate in patient engagement councils, patient advocacy groups, and consumer advisory councils with a focus on older adults Conduct awareness campaigns to educate older adults on specific diseases and conditions known to have a high prevalence of malnutrition <ul style="list-style-type: none"> Examples and opportunities include ASPEN’s annual Malnutrition Awareness Week™ and National Nutrition Month in March Educate older adults and caregivers on “what is optimal nutrition to correct misconceptions (eg, eating means you are not malnourished), and provide resources to access nutrition services such as through the Older Americans Act Nutrition Programs and USDA Food Assistance Programs
Educate and Raise Visibility with State and Local Policymakers	<ul style="list-style-type: none"> Identify state policy key opinion leaders to advocate for malnutrition care quality policies to be incorporated across all care settings Educate legislators and regulators on priority areas for malnutrition prevention, identification, diagnosis, and treatment

Taking Policy Action on Older Adult Malnutrition /

There are many different ways states can take policy action on older adult malnutrition. These include state legislation, proclamations, state resolutions for Malnutrition Awareness Week™, constituent communications, and other state-specific activities.

State Legislation

Several states have taken the lead in legislative actions related to older adult malnutrition, including resolutions recognizing Malnutrition Awareness Week™ (a program of the American Society for Parenteral and Enteral Nutrition) and legislation establishing Malnutrition Prevention Commissions, as outlined below. See Appendix H for malnutrition policy through the decade.

State	Year	Legislation
Recognizing Malnutrition Awareness Week		
Illinois	2013-14	House Resolution 418*
Indiana	2013-14	House Concurrent Resolution 24*
Louisiana	2013-14	Senate Concurrent Resolution 41*
Ohio	2013-14	House Resolution 306*
Florida	2015-16	Senate Resolution 550*
Georgia	2015-16	Senate Resolution 254*
Texas	2015-16	House Resolution 1419*
New Mexico	2015-16	House Memorial 104*
Establishing Malnutrition Prevention Commission		
Massachusetts	2015-16	Senate Bill 2499**
Ohio	2015-16	House Bill 580**
Other		
Virginia	2016-17	Senate Bill 1437** Including strategies related to malnutrition in duties of Commonwealth Council on Aging
Connecticut	2018-19	House Bill 7338** Increasing funding for elderly nutrition, ensuring equitable rates for providers of Meals on Wheels, and collecting data on malnutrition

*Adopted/ **Passed

Proclamations and Partners

State governors and officials have made proclamations to support Malnutrition Awareness Week™. In 2020, state proclamations were issued in Alabama, Florida, Massachusetts, Nevada, New Jersey, New York, South Carolina, South Dakota, Texas, Utah, and Wisconsin. A sample resolution recognizing Malnutrition Awareness Week™ is provided in Appendix E.

In addition, multiple state leadership groups have taken specific policy actions, including the National Organization of Black Elected Leaders—Women (NOBEL-Women) adopting a malnutrition resolution in 2012, 2016, 2019, and 2020; the National Lieutenant Governors Association adopting a malnutrition resolution in 2020; and the National Conference of State Legislatures, Standing Committee on Health and Human Services adopting a policy supporting establishing malnutrition care as a measure of quality healthcare. These organizations present best practices and provide policy recommendations that can be adapted for different states.

Constituent Actions

Increasing constituent awareness about the issue of older adult malnutrition is also important. In 2020, the Florida Commissioner of Agriculture issued a proclamation and released a video, press release, and social media calling attention to the issue during Malnutrition Awareness Week™. Samples of a constituent communication, social media, an op-ed, and graphics are included in Appendices B, C, and D. There is a need to improve constituent awareness about malnutrition intervention too. Many state legislative offices often serve in the role of case worker to help connect constituents with state and local services and resources. There are a number of stakeholders involved in administering nutrition assistance programs on page 10. Constituents may benefit when provided specific resource links for meals and food assistance programs for older adults on page 10.

Older adult malnutrition was included in the Massachusetts Health Council's 2017 *Common Health for the Commonwealth Report on Preventable Conditions and Social Determinants of Health*. Further, state commissions and workgroups on malnutrition have published state-specific reports on older adult malnutrition, including the Massachusetts Commission on Malnutrition Prevention Among Older Adults 2018 and 2019 reports,²³ the Ohio Malnutrition Prevention Commission 2018 report, and the *State of the State: Malnutrition Among Florida's Senior Population, a Proposal for Living Healthy in Florida*.

In several individual states, stakeholders are working together in unique ways to achieve the common objectives of increasing awareness about the public health crisis of older adult malnutrition and identifying and implementing possible solutions. On the following pages are some examples of how states have approached this issue. Please contact the Defeat Malnutrition Today coalition if you would like more information on a specific state.



State Best Practices /



Connecticut

Connecticut legislators held a roundtable discussion focused on the impact of malnutrition. It was hosted by two state policymakers and several key stakeholders, including the Connecticut Nurses Association.

Additionally, an expanded network of stakeholders supported legislation, which passed in 2019, to increase funding for older adult nutrition, ensure equitable rates for providers of home-delivered meals, and collect and analyze data on malnutrition.



Florida

Advocates worked together to support the development, publication, and pull-through of a report by the Florida Department of Agriculture and Consumer Services, titled *State of the State: Malnutrition Among Florida's Senior Population, a Proposal for Living Healthy in Florida*. This report assessed malnutrition risk and impact among Florida's senior population and provided insight into potential solutions. The Florida Malnutrition Workgroup membership is geographically diverse, and its members have strong clinical backgrounds and years of experience working with older Floridians. Some members of the workgroup are the Osceola Council on Aging, Healthy St. Lucie, Lee Memorial Health, and the Florida Council on Aging. The Florida Academy of Nutrition and Dietetics leads the workgroup, whose priorities include:

- Distributing the State of the State malnutrition report
- Integrating Defeat Malnutrition Today's *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* into the purpose of the workgroup to:
 - Ensure high-quality transitions of care
 - Consider implementation of a malnutrition screening tool during hospitalization and discharge
 - Identify quality gaps in malnutrition care
 - Define nutrition roles of the interdisciplinary team and engage nurses, social workers/case managers, and physicians
 - Track clinically relevant nutrition-related health data
- Engaging with the Florida Department of Agriculture and Consumer Services during Malnutrition Awareness Week™ and promoting activities at the state capitol, including securing approval of proclamation



A malnutrition network of 24 stakeholder groups worked together to advocate for passage of a bill in 2016 to establish a Malnutrition Commission focused on older adults. The network also worked to identify nominations for the Commission membership and to follow through on the appointee process. The Massachusetts Malnutrition Commission meets regularly and submits annual reports to the governor that have included these recommendations:

- Data Collection and Management
 - Massachusetts Executive Office of Elder Affairs will require all Area Agencies on Aging (AAAs), Aging Services Access Points (ASAPs), and nutrition service providers to include the Malnutrition Screening Tool (MST) in their intake process
 - Healthcare, primary care, and other providers working across a spectrum of settings (assisted living facilities, community health centers and other outpatient settings, and food banks) should be encouraged to use the MST at intake to identify their clients/patients with high malnutrition risk
 - Hospital discharges should flag “malnutrition risk” and refer those patients for nutrition counseling at community organizations (eg, an ASAP) using the Malnutrition Quality Improvement Initiative (MQii) discharge protocol
- Public Awareness
 - An annual Massachusetts Older Adult Malnutrition Awareness Week should be established in May to align with the national Older Americans Month
 - Healthcare stakeholders should collaborate on conducting a Malnutrition Awareness Campaign at state legislative gatherings and community health promotion events
 - All member agencies of the Commission should publish and promote evidence-based malnutrition resources designed for older adults, care providers, and professionals via websites, social media, and printed materials such as newsletters
- Dissemination and Best Practices
 - National research centers or academic institutions should conduct/publish evidence-based malnutrition research as it becomes available
 - Community organizations and healthcare providers should conduct medical nutrition therapy (MNT) to treat malnutrition

Beyond the Commission, the network continues to work toward its objectives regarding malnutrition, including:

- The governor’s administration’s fiscal year 2020 budget proposal included a \$2.4 million increase for the Senior Nutrition Program, which was a first in the Commonwealth
- The mayor proclaimed May 13 to May 20, 2019, as Older Adult Malnutrition Awareness Week in Boston, Massachusetts:
 - Throughout the week, more than 80 senior malnutrition clinics were offered and attended by 2,930 individuals
 - Screening clinics addressed misconceptions in regards to malnutrition, and individual malnutrition risk screening (using the MST) and frailty risk screening were performed
 - 82 (10%) of those screened were found at risk for malnutrition per the MST, and 15 (18%) of these had been admitted to the hospital in the last 3 months
 - Of those screened with the FRAIL scale, 99 (16%) were frail and 256 (41%) were identified as pre-frail. 23 (6%) of those screening as frail and pre-frail had been admitted to the hospital in the past 3 months
 - Findings indicated that it is important to address barriers to adequate nutrition, intervene early, and try to prevent those found at risk for malnutrition and those identified as pre-frail from progressing to frailty
- An Older Adult Malnutrition Awareness and Prevention Week webpage was created on the Massachusetts Nutrition Program for Seniors website
- The governor declared September 24 to 28, 2019, as Malnutrition Awareness Week™ in the state of Massachusetts

In 2020, the network worked with the Massachusetts Executive Office of Elder Affairs to develop and implement a social media campaign, #BeaNutritionNeighbor, that encouraged people to check in on their at-risk community members during the COVID-19 pandemic. In addition, a customized social media toolkit was disseminated in the fall during Malnutrition Awareness Week™.

On an ongoing basis, the network continues to support successful implementation of legislation and key initiatives (eg, Community Servings Food Is Medicine State Plan, Massachusetts Health Council’s Indicator Report) that relate to malnutrition and the work of the Massachusetts Malnutrition Commission.

 **Ohio**

A network of stakeholders successfully advocated for passage of Ohio Senate Bill 245, which established the Ohio Malnutrition Prevention Study Commission. The Commission was required to convene for a single term from 2017 to 2018, and submit a report to the Governor's office with their final recommendations.

Key findings of the commission's report included:

- Chronic diseases such as cancer, stroke, diabetes, and heart disease and their treatments can result in changes in nutrient intake and ability to use nutrients, which can lead to malnutrition
- In 2017, 671,333 older Ohioans were isolated and living alone; 443,770 were threatened by hunger, and 694,565 were living at or near the poverty line
- Patients who are malnourished while in the hospital have a greater risk of complications, falls, pressure injuries, infections, readmissions, and a longer length of stay, which is associated with up to a 300% increase in costs
- Malnourished hospital patients have up to five times increased mortality

With the end of the single-term commission, the group transitioned to the Ohio Malnutrition Working Group with the goal of implementing the commission's recommendations. This has led to the creation of a clinical malnutrition screening tool, which combines malnutrition and food insecurity risk screening (Appendix I). The Ohio Malnutrition Working Group piloted a study of the screening tool at the Charitable Pharmacy in Columbus. With the successful completion of that study, the working group is working to expand use of the tool with additional organizations across the state. Some stakeholders in Ohio are the Ohio Academy of Nutrition and Dietetics, the Ohio Pharmacists Association, and ASPEN.

 **Texas**

Stakeholder partners worked together to support a study on malnutrition among older Texans, in collaboration with Texas A&M University, Texas A&M AgriLife, the Texas Academy of Nutrition and Dietetics, and Meals on Wheels. The study is now complete and lead researchers are seeking publication. Once the study is published, stakeholder partners will share and elevate key findings and continue to expand the base of stakeholder partners to support implementation of recommendations, including any policy priorities that emerge from the study.

 **Utah**

A Utah Malnutrition Advocacy Taskforce launched in May 2020 and created a broad-based coalition of malnutrition advocates from a diverse array of organizations across the state. The focus has included developing social media and website content, newsletters, and a COVID-19 malnutrition proclamation, sharing information about ongoing malnutrition work, and laying groundwork for future policy work.

To date, the taskforce has supported a Legislative Advocacy Day at the Utah state capitol that promoted issue awareness and provided resource materials for policymakers. The taskforce also conducted a social media campaign on the need to assess and protect older adult nutrition status during COVID-19 and successfully pursued a governor's proclamation on malnutrition awareness during COVID-19.

Key Takeaways

- Inform your state policymakers on actions to improve quality of malnutrition care for older adults. Examples include requiring state-based home care standards for training all home-based caregivers regarding nutrition, food safety, and identification of signs and symptoms of malnutrition.
- Educate your community and state policymakers on the impact, prevention, and treatment of malnutrition and the available resources to fight it.
- Link older adults to community resources that address food insecurity.
- Ask your state legislators to recognize Malnutrition Awareness Week™, establish a malnutrition prevention commission, or increase funding for older adult nutrition programs.

Appendix A: Resources on Health and Nutrition Advocacy and Malnutrition /

Resources for Health and Nutrition Advocacy

- WIG Nutrition for Vulnerable Populations Podcast: https://www.womeningovernment.org/policies_publications/policy-issues/nutrition-vulnerable-populations

Resources for Recognizing Malnutrition

- Gerontological Society of America’s “What Is Malnutrition,” available at <https://bit.ly/GSA-infog>
- American Society for Parenteral and Enteral Nutrition’s “Malnourished Hospitalized Patients Are Associated With Higher Costs, Longer Stays & Increased Mortality,” available at <https://bit.ly//ASPEN-infog>
- Alliance for Aging Research’s “Malnutrition: A Hidden Epidemic in Older Adults,” available at <https://www.youtube.com/watch?v=iPNZKyXqN1U>

Resources for Educating Patients, Families, and Caregivers on How to Address Malnutrition

- National Council on Aging’s “Healthy Eating Tips for Seniors,” available at <https://www.ncoa.org/article/healthy-eating-tips-for-seniors>
- Alliance for Aging Research’s malnutrition tip sheet “Malnutrition: A Hidden Epidemic in Older Adults,” available at <https://bit.ly/AAR-tips>
- Meals on Wheels America’s “Hunger in Older Adults: Challenges and Opportunities for the Aging Services Network,” available at <https://bit.ly/MOWA-report>

Access to Adequate Food and Nutrition

- National Council on Aging’s BenefitsCheckUp service, available at <https://benefitscheckup.org/>
- “Implementing Food Security Screening and Referral for Older Patients in Primary Care,” available at <https://bit.ly/AARP-screen>
- “Combating Food Insecurity: Tools for Helping Older Adults Access SNAP,” available at <https://bit.ly/FRAC-SNAP>
- “Food Distribution Program on Indian Reservations,” available at <https://bit.ly/FDPIRfacts>
- US Department of Agriculture’s “Fact Sheet: USDA Support for Older Americans,” available at <https://bit.ly/USDA-seniors>

Studies/Papers

- Addressing Disease-Related Malnutrition in Hospitalized Patients: A Call for a National Goal (2015): <http://bit.ly/2015-DAMpaper>
- Aging Policy: Preventing, Treating Malnutrition to Improve Health and Reduce Costs (2014): <http://bit.ly/GSA-malnutrition>
- Call for Action for Malnutrition Policy (2019): <http://bit.ly/JAND-calltoaction-2019>
- Economic Burden of Community-Based Disease-Associated Malnutrition in the United States (2014): <http://bit.ly/DAM-2014>
- Economic Burden of Disease-Associated Malnutrition at the State Level (2016): <http://bit.ly/DAM-state>
- Malnutrition Quality Improvement Initiative Yields Value for Interdisciplinary Patient Care and Clinical Nutrition Practice (2019): <http://bit.ly/JAND-mal-supp>
- Malnutrition Vigilance During Care Transitions (2015): <http://bit.ly/mal-2015>

Appendix A: Resources on Health and Nutrition Advocacy and Malnutrition (cont.) /

Organizational Resolutions

- Government Accountability Office Report on Nutrition Assistance Programs: <http://bit.ly/GAO-report>
- National Black Nurses Association Resolution: <http://bit.ly/NBNA-res>
- National Lieutenant Governors Association Resolution: <http://bit.ly/NLGA-res>
- National Organization of Black Elected Leaders (NOBEL)-Women Resolution <http://bit.ly/NOBEL-W-res>

Toolkits and Other Resources

- Alliance for Aging Research Malnutrition Tools
 - film: <https://www.youtube.com/watch?v=iPNZKyXqN1U>
 - resources: <http://www.agingresearch.org/malnutrition>
 - press release: <https://www.agingresearch.org/press-release/press-kit-for-malnutrition-a-hidden-epidemic-in-older-adults/>
 - film in Spanish: <https://www.youtube.com/watch?v=ADfqv42L7KI>
 - ASPEN Malnutrition Toolkit: <http://bit.ly/ASPEN-mal>
- Community Malnutrition Resource Hub: <http://bit.ly/mal-hub>
- Congressional Research Service Memo on Malnutrition in Older Adults: <http://bit.ly/CRS-mal-memo>
- Dialogue Proceedings, Advancing Patient-Centered Malnutrition Care Transitions: <http://bit.ly/dialogue-caretrans>
- Food Is Medicine Advocacy Toolkit: <http://bit.ly/FIMC-advocacy>
- Letter to CMS from House Members on Quality Measures: <http://bit.ly/CMS-2019-malletter>
- Malnutrition Policy Fact Sheet: <http://bit.ly/mal-policy-sheet>
- Malnutrition Quality Improvement Initiative (MQii) Toolkit: <http://bit.ly/MQii-toolkit>
- National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update: <http://bit.ly/malblueprint-2020>
- National Blueprint 2020 infographic: <http://bit.ly/malinfog-2020>

Appendix B: Sample Social Media /

The topic of older adult malnutrition can be important to your constituents. Use these sample social media posts to help increase awareness about the problem of older adult malnutrition.

Social Media Posts

Twitter

- Quality measures for malnutrition care are needed to help ensure older Americans get the care they need
- As many as 1 of 2 older adults aged 65+ is malnourished or at risk for #malnutrition
- Malnutrition awareness is imperative for better clinical outcomes. Let's learn about and address #malnutrition in the US
- #Malnutrition is more common in the US than you think: Half of US older adults are at risk!
- Being malnourished puts Americans at risk for serious health consequences. #Malnutrition Awareness is crucial
- Did you know that obesity isn't the only nutritional epidemic in America? #Malnutrition affects thousands
- The yearly cost of disease-associated #malnutrition in older adults is more than \$51.3 billion!
- Did you know that up to 1/2 of US older adults may be at risk for #malnutrition? Learn the facts & join us in speaking up
- #Malnutrition in the hospital setting often goes undiagnosed, leading to serious adverse effects
- You don't have to look unhealthy to suffer signs of #malnutrition. Learn the risk factors!
- When it comes to #malnutrition, you aren't helpless. Empower yourself and your loved ones by asking for a nutrition care plan and getting the facts

HB/SB-Specific Posts

- Join me in supporting HB/SB#### so that we can defeat #malnutrition today!
- I introduced HB/SB#### to end the PREVENTABLE burden of #malnutrition in STATE
- HB/SB#### aims to bring #malnutrition awareness to improve clinical outcomes in our state. It is time to defeat #malnutrition today!
- Up to 1/2 of older adults are at risk for #malnutrition – Please support HB/SB#### to help us end this preventable health risk!
- #Malnutrition costs our state \$_per year! HB/SB#### will help end this preventable health crisis!

Content for Specific Conditions

Oncology

- #Malnutrition is common among cancer patients because the disease can affect the ability to digest food and absorb nutrients. <http://bit.ly/1MECGSZ>
- #Malnutrition is common among cancer patients. Treatment can impede the body's ability to get the best nutrition. <http://bit.ly/1MECGSZ>

Diabetes

- Preventing and treating #malnutrition is important in helping manage and treat diabetes and preventing or slowing complications. <http://bit.ly/1MECGSZ>

Kidney Disease

- Malnutrition frequently complicates chronic kidney disease and end-stage renal disease <http://bit.ly/1MECGSZ>
- Malnutrition can affect up to 75% of acute kidney injury and acute renal failure (ARF) patients <http://bit.ly/1MECGSZ>

Appendix B: Sample Social Media (cont.) /

Surgery

- Malnutrition can make recovery from surgery more challenging. Policies like Enhanced Recovery After Surgery (ERAS) help ensure surgery candidates are well nourished pre- and post-op. <https://www.defeatmalnutrition.today/pt-resources>

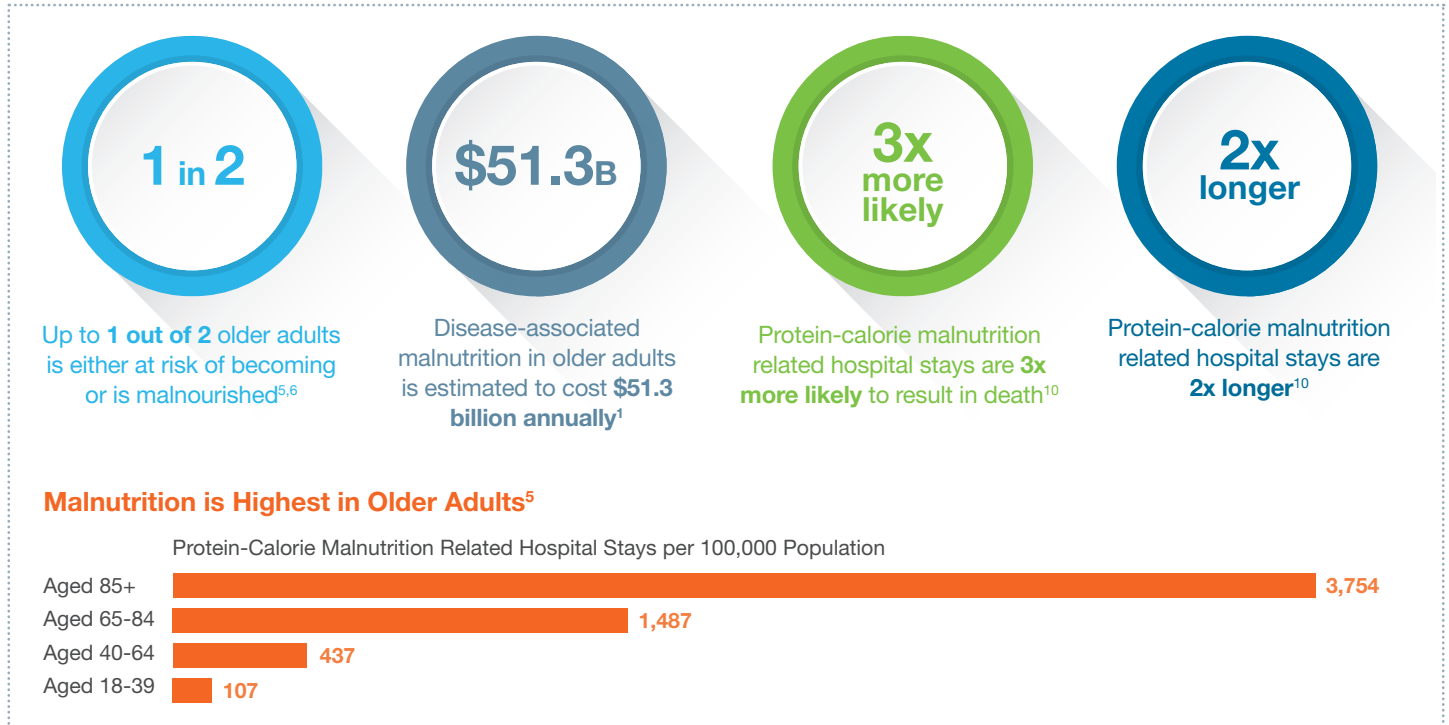
Additional Content for Facebook, Instagram, and LinkedIn:

(Note: The following content contains too many characters for Twitter)

- Do you have a family member who was affected by #malnutrition? Share your story on Instagram and Facebook using #malnutrition. You can also share your story on Defeat Malnutrition Today's website, <https://www.defeatmalnutrition.today/your-malnutrition-story>. Together we can make a difference and raise awareness.
- Why are we speaking up about #malnutrition? Because we want to see decreased mortality & improved quality of life. Share this status if you know someone who has suffered from #malnutrition. Take on #malnutrition. Enhance patient safety. <http://bit.ly/2aMNvkQ>
- Did you know that surgical patients with #malnutrition have a four times higher risk of pressure ulcer development? Learn more about malnutrition and ways to reduce these risks at <http://defeatmalnutrition.today>
- In some studies, 30-50% of patients become malnourished, often during a hospital stay. Educate yourself on the signs and risk factors for malnutrition at defeatmalnutrition.today

Appendix C: Sample Graphics /

Figure 1: Malnutrition is a Critical Public and Patient Safety Issue (national data)



MALNUTRITION: AN OLDER ADULT CRISIS

UP TO 1 OUT OF 2 OLDER ADULTS are at risk for malnutrition¹

\$51.3 BILLION Estimated annual cost of disease-associated malnutrition in older adults in the US²

PROTEIN-CALORIE MALNUTRITION RELATED HOSPITAL STAYS ARE 2X LONGER³

MALNUTRITION LEADS TO more complications, falls, and 30-day readmissions^{3,4}

PROTEIN-CALORIE MALNUTRITION RELATED HOSPITAL STAYS ARE 3X MORE LIKELY to result in death³

MALNUTRITION IS HIGHEST IN OLDER ADULTS³

Protein-Calorie Malnutrition Related Hospital Stays per 100,000 Population

Aged 85+	3,754
Aged 65-84	1,487
Aged 40-64	437
Aged 18-39	107

JUST 4 STEPS CAN HELP IMPROVE OLDER ADULT MALNUTRITION CARE

- SCREEN** all patients
- +**
- ASSESS** nutritional status
- +**
- DIAGNOSE** malnutrition
- +**
- INTERVENE** with appropriate nutrition

FOCUSING ON MALNUTRITION IN HEALTHCARE HELPS:

- ✓ Decrease healthcare costs⁵
- ✓ Improve patient outcomes⁵
- ✓ Reduce readmissions
- ✓ Support healthy aging
- ✓ Improve quality of healthcare

Support policies across the healthcare system that defeat older adult malnutrition.

Learn more at www.DefeatMalnutrition.Today

References: 1. Kaiser MJ, et al. J Am Geriatr Soc. 2010;58(9):1734-1738. 2. Snider JT, et al. JPEN J Parenter Enteral Nutr. 2014;38(2 suppl):775-855. 3. Barrett ML, Bailey MK, Owens PL. U.S. Agency for Healthcare Research and Quality. www.hcup-us.ahrq.gov/reports.jsp. Published 2018. 4. Norman K, et al. Clin Nutr. 2008;27(1):5-15. 5. Philipson TJ, et al. Am J Manag Care. 2013;19(2):121-128. © Copyright 2019

Appendix D: Federal Nutrition Assistance Programs Serving Older Adults and Opportunities for State Legislators /

Program	Eligible population	Type of assistance	No. of older adult participants in 2017	Total federal appropriations in FY 2020*	Opportunities for state legislators
HHS Administration for Community Living					
Home-Delivered Nutrition Program	Adults 60 years or older	Prepared meals delivered to participants who are usually homebound	850,880	\$266 million	This program relies on federal, state, and local funding and will benefit from state legislation supporting additional funding
Congregate Nutrition Program	Adults 60 years or older	Prepared meals provided in congregate settings, such as senior centers	1,520,507	\$510 million	This program relies on federal, state, and local funding and will benefit from state legislation supporting additional funding
USDA Food and Nutrition Service					
Supplemental Nutrition Assistance Program (SNAP)	Households, including those with older adults with low income	Benefits to purchase food in participating retail stores	5,447,000	\$67.9 billion	SNAP is a fully funded federal program, and older adults will benefit from state legislation streamlining enrollment as well as awareness campaigns promoting enrollment
Commodity Supplemental Food Program (CSFP)	Adults 60 years or older with low income	A monthly supplemental package of shelf-stable foods and refrigerated cheese	675,926	\$245 million	This federal program may not be well-known, and older adults will benefit from promotion of information about this program
Child and Adult Care Food Program (CACFP)	Adults who are physically or mentally impaired or adults 60 years or older enrolled in an adult day care program	Prepared meals provided in nonresidential adult day care centers	134,694	\$4.8 billion	CACFP is not a fully funded federal program and will benefit from state legislation supporting additional funding
Senior Farmers' Market Nutrition Program (SFMNP)	Adults who are 60 years or older with low income	Benefits to purchase locally grown fruits, vegetables, honey, and herbs from farmers' markets, roadside stands, and community programs	834,875	\$18.5 million	SFMNP is not a fully funded federal program and will benefit from state legislation supporting additional funding

* Additional appropriations during the COVID-19 pandemic as of January 2021 include \$925 million total for home-delivered and congregate nutrition programs and \$15.8 billion for the Supplemental Nutrition Assistance Program.

Appendix E: Sample Resolution Recognizing Malnutrition Awareness Week /

Older adults are one of the groups at greatest risk for malnutrition. However, there are other groups who are vulnerable to, and can be impacted by, the global COVID-19 pandemic and could be included in a resolution, as shown below.⁸

A resolution commending the benefits of systematic nutrition screening and intervention and recognizing the first week of September as “Malnutrition Awareness Week™” in the state of [State].

WHEREAS, experts agree that nutrition status is a direct measure of patient health and that good nutrition can keep people healthy and out of healthcare institutions, thus reducing healthcare costs, which can be up to \$49 billion annually for hospital stays involving malnutrition; and

WHEREAS, inadequate or unbalanced nutrition, known as malnutrition, is particularly prevalent in vulnerable populations, such as hospitalized patients, older adults, and underserved populations, and those populations statistically shoulder the highest incidences of the most severe chronic illnesses such as diabetes, kidney disease, cancer, and cardiovascular disease that are also impacted by nutrition; and

WHEREAS, malnutrition is exacerbated by the global COVID-19 health pandemic that has intensified disparities and social isolation for older adults and is further compounded by food insecurity, and federal legislation has allocated supplemental funding for federal community nutrition programs; and

WHEREAS, illness, injury, and malnutrition can result in the loss of lean body mass, leading to complications that impact good patient health outcomes, including recovery from surgery, illness, or disease; and

WHEREAS, Enhanced Recovery After Surgery (ERAS®) care plans implemented by a team of multidisciplinary healthcare professionals can improve patient nutrition to support a strong recovery and help reduce risk of complications from surgeries; and

WHEREAS, despite the recognized link between good nutrition and good health, nutrition screening and intervention have not been systematically incorporated across the continuum of care; and

WHEREAS, clinical quality measures can help improve nutrition screening and intervention, and the Centers for Medicare & Medicaid Services (CMS) for the first time has approved multiple malnutrition-specific clinical quality measures for two CMS qualified clinical data registries; and

WHEREAS, a collaborative effort among key stakeholders in the public and private sectors continues to be required to increase awareness of, reduce, and prevent malnutrition, and the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* serves as a template for such collaboration; and

WHEREAS, the [Names of Local Supporting Groups] recognize that an important step toward identifying and treating malnutrition is raising awareness about it and thus join with the American Society for Parenteral and Enteral Nutrition (ASPEN), which was the first to establish a national Malnutrition Awareness Week™ in 2012.

NOW, THEREFORE, BE IT RESOLVED by the [Legislative Body] of the State of [State] that September XX to XX is recognized as “Malnutrition Awareness Week™” in [State] (see <http://www.nutritioncare.org/maw/> for yearly dates).

Appendix F: Qualified Clinical Data Registries (QCDRs) /

A Qualified Clinical Data Registry (QCDR) is a Centers for Medicare & Medicaid Services (CMS) approved registry that collects data from reporting clinicians with the goal of improving healthcare quality. QCDR organizations may include specialty societies, regional health collaboratives, large health systems, or software vendors working in collaboration with one of these medical entities. QCDRs can be used to report quality measure data, practice improvement, and EHR use that is more specific to the quality care goals of the organization or society. CMS may also approve measures in a QCDR for MIPS (Merit-based Incentive Payment System) reporting by eligible clinicians to receive credit for quality of care. This credit is a core determining factor for performance-based payment adjustments to Medicare reimbursement as part of MIPS participation, which is mandatory for most Medicare providers who meet minimum criteria.⁸

Effective January 1, 2020, the following malnutrition-related measures, stewarded by the Academy of Nutrition and Dietetics (Academy), were adopted by the Premier Clinical Performance Registry and the US Wound Registry. In each respective QCDR, 2 measures were approved by CMS for MIPS reporting, while 2 other measures are also reportable for quality improvement but do not grant MIPS credit. The Academy has published a guide for orienting providers to MIPS participation and reporting of the malnutrition quality measures to each respective QCDR.⁸

Visit this link for the Academy’s guide: <https://bit.ly/and-qcdr>

	Premier Clinician Performance Registry	U.S. Wound Registry
Measure #1	Measure Title: Completion of a Screening for Malnutrition Risk and Referral to a Registered Dietitian Nutritionist (RDN) for At-Risk Patients	Measure Title: Completion of a Screening for Malnutrition Risk and Referral to a RDN for At-Risk Patients
Measure #2	Measure Title: Assessment of Nutritionally At-Risk Patients for Malnutrition and Development of Nutrition Recommendations/Interventions by a RDN	Measure Title: Assessment of Nutritionally At-Risk Patients for Malnutrition and Development of Nutrition Recommendations/Interventions by a RDN
Measure #3	Measure Title: Appropriate Documentation of Malnutrition Diagnosis	Measure Title: Obtaining Preoperative Nutritional Recommendations from a RDN in Nutritionally At-Risk Surgical Patients
Measure #4	Measure Title: Nutritional Care Plan Communicated to Post-Discharge Provider	Measure Title: Appropriate Documentation of Malnutrition Diagnosis
Key	Measures Approved for MIPS Reporting	Measures Adopted by Registry, Not Approved for MIPS Reporting

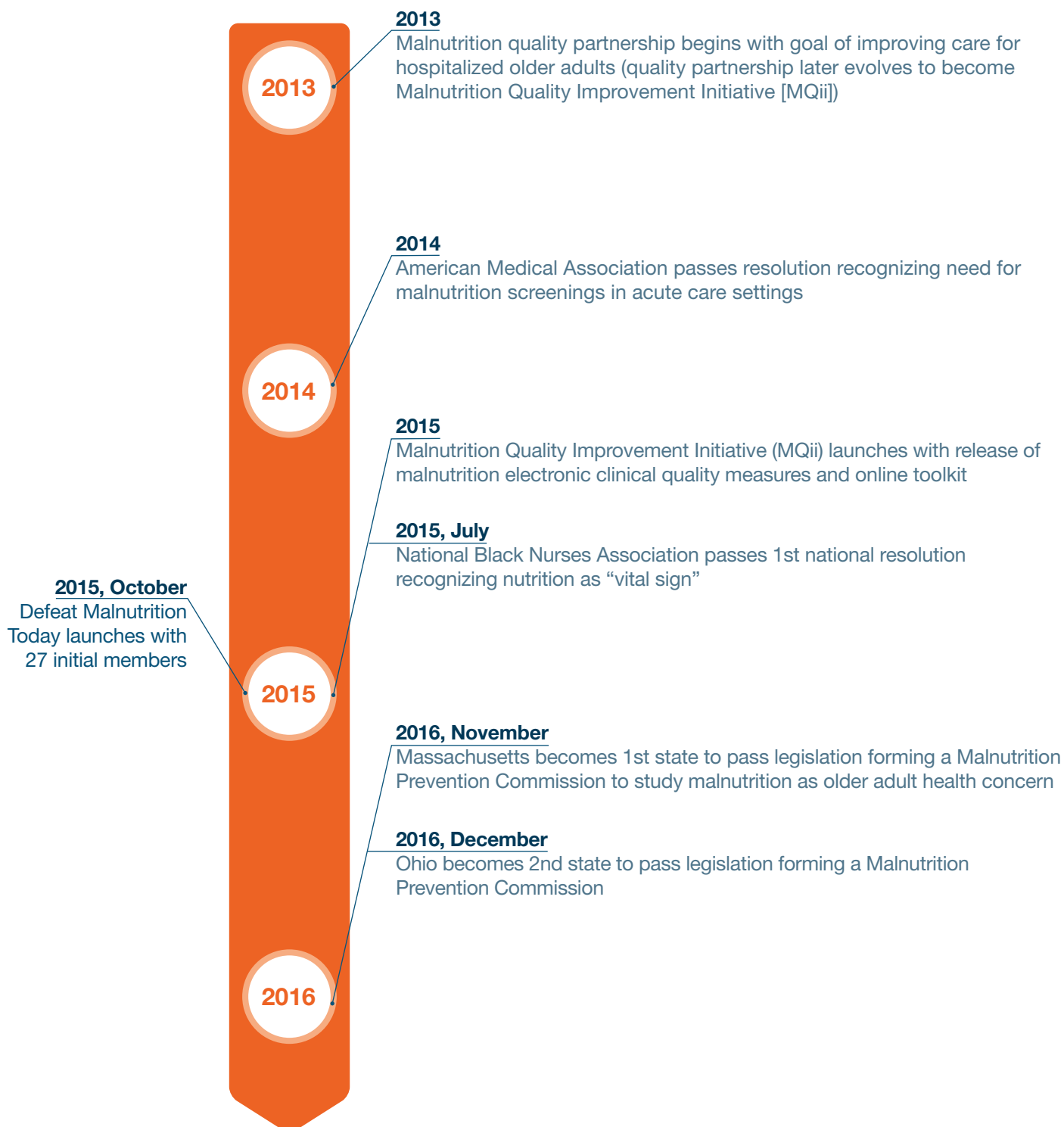
Appendix G: State Costs of Disease-Associated Malnutrition /

Estimated Annual Costs and Per Capita Costs by State of Disease-Associated Malnutrition for Adults Aged 65 Years and Older²²

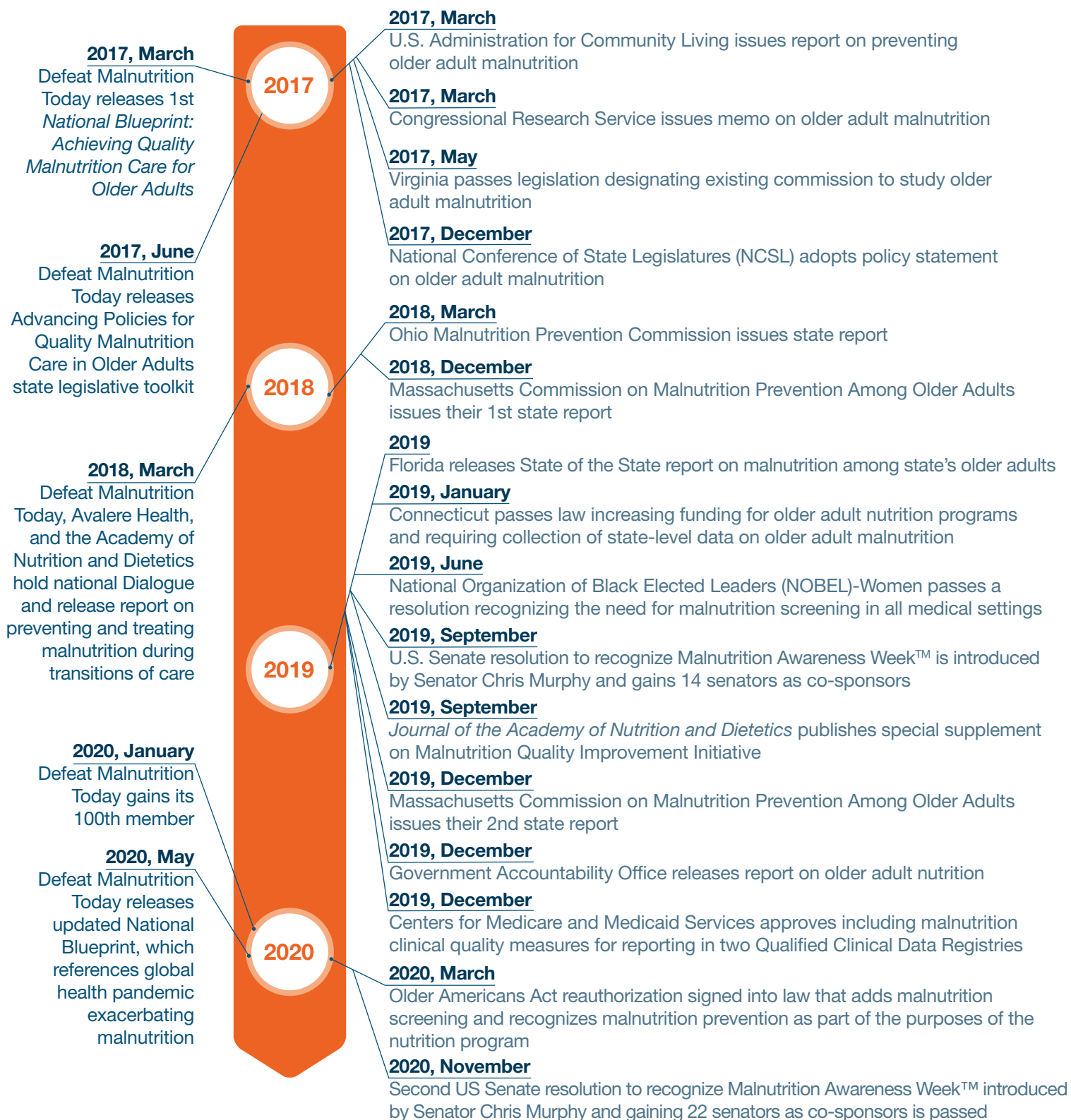
STATE	ANNUAL COSTS (AGED 65+)	PER CAPITA COSTS (AGED 65+)
Alabama	\$71,968,488	\$96
Alaska	\$7,091,582	\$100
Arizona	\$95,796,376	\$89
Arkansas	\$42,740,348	\$91
California	\$492,571,488	\$97
Colorado	\$60,418,264	\$88
Connecticut	\$49,822,676	\$89
Delaware	\$14,656,278	\$95
District of Columbia	\$9,390,157	\$124
Florida	\$346,982,176	\$91
Georgia	\$125,373,000	\$99
Hawaii	\$31,726,716	\$124
Idaho	\$20,377,088	\$87
Illinois	\$167,950,480	\$93
Indiana	\$83,279,520	\$88
Iowa	\$41,757,180	\$85
Kansas	\$36,615,524	\$87
Kentucky	\$57,608,312	\$87
Louisiana	\$63,654,108	\$100
Maine	\$20,817,142	\$85
Maryland	\$84,344,672	\$102
Massachusetts	\$90,326,104	\$88
Michigan	\$141,127,008	\$92
Minnesota	\$67,790,480	\$87
Mississippi	\$43,148,340	\$100
Missouri	\$84,043,568	\$89

STATE	ANNUAL COSTS (AGED 65+)	PER CAPITA COSTS (AGED 65+)
Montana	\$15,137,121	\$88
Nebraska	\$23,409,542	\$86
Nevada	\$38,848,784	\$95
New Hampshire	\$18,116,064	\$85
New Jersey	\$124,254,664	\$94
New York	\$281,050,912	\$90
New Mexico	\$28,918,304	\$96
North Carolina	\$140,348,592	\$95
North Dakota	\$9,025,682	\$86
Ohio	\$162,532,560	\$90
Oklahoma	\$53,003,912	\$92
Oregon	\$56,126,272	\$87
Pennsylvania	\$190,557,488	\$89
Rhode Island	\$14,485,806	\$87
South Carolina	\$74,782,944	\$98
South Dakota	\$11,368,387	\$87
Tennessee	\$90,469,296	\$91
Texas	\$287,602,336	\$92
Utah	\$25,761,394	\$87
Vermont	\$9,114,263	\$85
Virginia	\$111,438,624	\$96
Washington	\$90,820,496	\$90
West Virginia	\$28,455,174	\$86
Wisconsin	\$76,195,096	\$87
Wyoming	\$7,177,984	\$87
National	4,320,378,880	\$93

Appendix H: Malnutrition Policy Through the Decade /



Appendix H: Malnutrition Policy Through the Decade (cont.) /



Appendix I: Sample Malnutrition and Food Insecurity Screening Tool /

This sample tool was developed and tested by the Ohio Malnutrition Working Group and can be adapted for use in other states.

Older Adult Malnutrition and Food Insecurity Screening

The Ohio Department of Health (ODH) recently convened a multi-stakeholder statewide commission to look at malnutrition in Ohio, and issued a report with policy recommendations and local strategies to address malnutrition (https://docs.wixstatic.com/ugd/c577a8_48c4ffc3726b4f64939760bb76f0c35b.pdf).

Partners in Central Ohio felt that the time had come to develop a common, regional plan to address senior malnutrition and ways to implement the ODH Commission Report’s policy recommendations. The first result of this work is the following tool that all providers—physicians (independent practices and hospitalists/specialists), nurses, social service agencies, care coordinators, and registered dietitians—can utilize to quickly identify BOTH malnutrition AND food insecurity risk with their older adult patients/clients, as well as provide direction and resources regarding next steps based on the results.

MALNUTRITION SCREENING TOOL ¹		
1. Have you recently lost weight without trying?		
No	0	
Not Sure	2	
Yes	1	
<i>If yes, how much weight have you lost?</i> 2-13 lbs	1	
14-23 lbs	2	
24-33 lbs	3	
34 or more lbs	4	
Unsure	2	Question 1 Score:
2. Have you been eating poorly because of decreased appetite?		
No	0	Question 2 Score:
Yes	1	
		Total Score:

Results

Questions 1 & 2 Total	
Score of 0-1	Patient is not at risk for malnutrition; screen again in 1 year or if condition changes.
Score of 2 or more	Patient is at risk for malnutrition and needs a referral to registered dietitian and/or a healthcare provider and ongoing monitoring.

¹ Ferguson M, et al. Nutrition. 1999;15(6):458-464.

Resources

- Find a [Registered Dietitian Nutritionist \(RDN\)](#)
- **Congregate Meals:** served in group settings, provide nutritious meals and opportunities for social interactions
- **Home Delivered Meals:** often referred to as “meals on wheels,” provides nutritious meals delivered to the door of older adults with limited mobility, who are homebound, or have a lack of transportation

Helpful Conversation Starters:

- Malnutrition can be caused by not getting enough of the nutrients your body needs to stay healthy or recover. You can be underweight or overweight and be malnourished. Have you ever been screened for malnutrition before?
- Have there been any changes in your health or life that may have caused weight loss?

For more information, visit the [Ohio Department on Aging](#).

Appendix I: Sample Malnutrition and Food Insecurity Screening Tool (cont.) /

FOOD INSECURITY SCREENING TOOL ^{1, 2}	
1. Within the last 12 months, I worried whether my food would run out before I had money to buy more.	
Often True	
Sometimes True	
Never True	
2. Within the last 12 months, the food I bought just didn't last and I didn't have money to get more.	
Often True	
Sometimes True	
Never True	



Results

Questions 1 & 2 Responses	
Never true for both questions	Patient is not food insecure; screen again in 1 year or if living conditions change.
Often true/sometimes true for one or both questions	Patient should be referred to meal services (see resources section) and/or a foodbank/food pantry; continue to monitor.

Resources

- **Congregate Meals:** served in group settings, provide nutritious meals and opportunities for social interactions
- **Home Delivered Meals:** often referred to as “meals on wheels,” provides nutritious meals delivered to the door of older adults with limited mobility, who are homebound, or have a lack of transportation
- **Senior Farmer’s Market Nutrition Program:** provides coupons for older residents that can be redeemed for fresh feeds from farmers’ markets and roadside stands (available in select counties)
- **Commodity Supplemental Food Program:** supplements the diets of older adults with nutritious foods
- **Supplemental Nutrition Assistance Program (SNAP):** provides nutrition benefits to supplement the food budget of those in need

Helpful Conversation Starters:

- Just like your medication is important to keep you healthy, food is medicine too. Have you ever learned about the importance of getting enough nutritious food before?
- Who typically does the shopping for food in your home?
- I noticed you are having trouble getting enough healthy foods. Are you aware of the options available to you to access food or resources to buy food?

For more information, visit the [Ohio Department on Aging](#).

¹ Hager ER, et al. Pediatrics. 2010;126(1): e26-e32.
² Gundersen C, et al. Public Health Nutr. 2017;20(8):1367-71.

Appendix J: Glossary of Terms /

Enteral nutrition²⁶: tube feeding for a person not able to eat any or enough food due to an illness or decreased appetite, difficulties swallowing, or some type of surgery that interferes with eating. The tube feeding liquid is a mixture that has protein, carbohydrates, vitamins, and minerals, given through a tube into the stomach or small intestine

Enhanced Recovery After Surgery (ERAS)²⁷: a care plan to help give patients a strong recovery and help reduce complications. The focus of the plan is to have good nutrition before and after surgery to help patients have a faster, stronger recovery

Food insecurity²⁸: a household-level economic and social condition of limited or uncertain access to adequate food. Ranges of food insecurity as defined by the USDA are as follows:

- Low food security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake
- Very low food security: reports of multiple indications of disrupted eating patterns and reduced food intake

Food security²⁸: access at all times to enough food for an active, healthy life for all household members. Ranges of food security as defined by the USDA are as follows:

- High food security: no reported indications of food-access problems or limitations
- Marginal food security: one or two reported indications—typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diet or food intake

Hunger²⁸: “an individual-level physiological condition that may result from food insecurity.” More generally, it is a sensation resulting from lack of food or nutrients, characterized by a dull or acute pain in the lower chest. Hunger is distinguished from appetite in that hunger is the physical drive to eat, while appetite is the psychological drive to eat, affected by habits, culture, and other factors

Malnutrition⁴: a state of deficit, excess, or imbalance in energy, protein, or nutrients that adversely impacts an individual’s own body form, function, and clinical outcomes

Malnutrition screening²⁹: the systematic process of identifying an individual with poor dietary or nutrition characteristics who is at risk for malnutrition and requires follow-up assessment or intervention

Medical nutrition therapy³⁰: nutritional diagnostic therapy and counseling services provided by a dietitian or nutritional professional for the purpose of managing disease following a referral by a physician

Merit-based Incentive Payment System (MIPS)³¹: a CMS quality payment program that determines Medicare payment adjustments. Under MIPS, clinicians are included if they are eligible clinician types and have low volume threshold, which is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule and the number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule

Older adult³²: adult 65 years or older, eligible to receive Medicare

Parenteral nutrition³³: intravenous (through the vein) administration of nutrition, which may include protein, carbohydrate, fat, minerals, and electrolytes, vitamins, and other trace elements

Qualified Clinical Data Registry (QCDR)³⁴: a CMS-approved vendor that collects clinical data from practitioners and reports this data to CMS on their behalf for payment model requirements as well as quality reporting purposes. QCDR organizations can include specialty societies, regional health collaboratives, large health systems, or software vendors that collaborate with one of these medical entities

Quality improvement³⁵: systematic activities that are organized and implemented by an organization to monitor, assess, and improve its healthcare with the goal of seeking continuous improvement in the care delivered to the patients the organization serves

Appendix J: Glossary of Terms (cont.) /

Quality indicator³⁶: measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality, of care provided

Quality measures³⁷: tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare

Social determinants of health³⁸: the environmental conditions in which individuals are born, live, learn, work, and age that affect their health, functioning, and quality-of-life outcomes and risks. Resources that enhance quality of life, including access to good nutrition and availability of healthy foods, can have a significant influence on population health outcomes

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